Improving Obstetric Triage

Strategies to Promote

Timely, Safe, and Cost Effective Care

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Obstetric Triage: Objectives

- Review perinatal triage including definitions and goals

- Compare and contrast medical-legal implications of telephone and outpatient triage care

- Determine the right time for a woman to transition from her home to the hospital for birth

- Describe how the anticipatory care provided by the obstetric triage nurse can prevent a complication from becoming a crisis
History of Triage, Legal Considerations, EMTALA
History of Triage

- French origin – to choose sort or classify
  - First use in Medicine during WWI
- 1960’s - used in hospital emergency rooms
  - Obstetric triage began in 1980’s
- Labor wards overburdened with patients that would not go onto deliver
  - Increased Patient volume in OB
  - Frees up critically needed labor beds
- Need for heightened maternal/ fetal surveillance
- Assessment of labor
- More effective utilization of staff and resources
Benefits of OB Triage Units

- Improves patient flow
- Decreases turn over costs
- Increases bed capacity
- Function as a holding unit
- Becomes the Gatekeeper to L&D
Multiple Functions of OB Triage Units

- Labor assessment and evaluation
- Decompression of labor and delivery
- Use as a holding area (busy L&D)
- Fetal evaluation and assessment
- Evaluation of medical/ OB complaints (after hours)
- Initial stabilization of OB complications
- Evaluation of OB referrals /transfers
- Triage OB telephone calls
- Selected OB procedures
- Source of OB care when normal source isn’t accessible or available
Value of the Nursing Role

- 1st to evaluate
- Detect abnormal s/sx
- Alert the team
- Optimize patient outcome
LEGAL CONSIDERATIONS

EMTALA

HIPPA
OB Triage, Active Labor, and EMTALA

- Emergency Medical Treatment and Labor Act
- Signed into federal law in 1986
  - Enacted as part of Consolidated Omnibus Budget Reconciliation Act (COBRA)

- Case review
  - Claudia Thomas: 19yo G₂P₁ @ 36 weeks

- Overall intent to ensure emergency services
  - Regardless of: ethnicity, insurance coverage, citizenship

- Pregnant women seek care for a urgent pregnancy problem (Instructed by their OB to go to hospital)
  - often without a previously scheduled appointment
  - 1/3 of all OB visits = criteria to designate ED rather than OB
EMTALA: Emergency Medical Treatment and Labor Act

Definition:

- Acute symptoms of sufficient severity (including severe pain such that the absence of immediate medical attention could pose serious jeopardy for mother or unborn child)
- A pregnant woman having contractions where there is inadequate time for transfer and may pose a health or safety threat to the mother or unborn child
EMTALA:
Emergency medical condition

- Mandates all pregnant women presenting to an ER, L&D, or OB Triage unit must have a medical screening examination (MSE).

EMTALA Requirements for Emergency Medical Treatment

POLICY 6.03.09
Patient Care EMTALA Requirements for Emergency Medical Treatment Issued: September 2000 Last Approval: December 2011
Categories of Risk in OB Triage

- **Patient Safety**
  - Assessment in a timely manner
  - Appropriate and complete evaluation and documentation
  - Discharge from OB Triage *without evidence of*
    - Fetal well-being
    - Recognizing active labor /discharged the woman in false labor
    - Delay in timely response from consultants
    - The use of clinical handoffs
Categories of Risk in OB Triage: Patient Safety

- **Pregnant women contracting have priority**
  - Must R/O active labor
  - Avoid treatment delays – consider chain of command

- **Determine what parameters are indicated for fetal assessment**
  - Fetal monitor $\rightarrow$ reactive tracing $\rightarrow$ further fetal testing
  - Implement intrauterine resuscitative measures

- **Prompt notification to Provider**
Legal Requirements of OB Triage

1. Perform a medical screening exam (MSE)
2. If emergency exists, notify MD and begin stabilization
3. Consider patient transfer
4. Arrange proper transfer
5. Patient evaluation and treatment cannot be delayed to obtain financial information
6. Women in labor are considered unstable from latent phase through delivery of placenta

Mahmeister and Van Mullen, 2000
EMTALA: Requirements for Transfer

- Medical Screening Exam
- Stabilization within the abilities of transferring facility
- Need for services not available at transferring facility or medical benefits of transport outweigh risks or patient/responsible person requests transfer
- Contact with receiving hospital to approve/accept transport
- Written certification by request of physician of need
- Records sent with the patient
- Appropriate method of transport used

Source: EMTALA (1986) in Angeli
EMTALA : Common Violations

- Improper refusal to accept a medically stable patient
- Improper refusal for an on-call practitioner to come in to see and examine in a timely manner
- Failure to properly complete a transfer certificate
- Failure to properly inform risk/benefit of transfer
- Failure to transfer an unstable patient with appropriate equipment and personnel
- Failure for a physician to rule out false labor
- Failure to accept a patient because of lack of ability to pay
- Failure to stabilize a patient to the facilities’ maximum ability prior to transfer
California Senate Bill 1152

- Background and Purpose
  - In order to standardize the level of discharge planning service hospitals provide, California Legislature passed, and the Governor signed SB 1152.
  - The law took effect, January 1, 2019
  - Purpose is to help prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter and other supportive services
  - The law does not require hospitals to find or create service that do not exist in the community.
  - Documented compliance with elements of this legislation are required by 1/1/2019.
California Senate Bill 1152

- **Services that Must be Offered to Homeless Patients Before Discharge**
  1. Physician Examination and determination of stability for discharge
  2. Referral for follow up care
  3. Referral for behavioral health care if it’s determined that the patient requires behavioral health care
  4. Food
  5. Weather appropriate clothing
  6. Discharge medications (prescriptions)
  7. Infectious disease screening
  8. Vaccinations appropriate to the presenting medical condition
  9. Transportation within 30 minutes or 30 miles of the hospital
  10. Screening for and assistance to enroll in affordable health insurance coverage
Recognizing Active Labor and Discharging the Pregnant Woman in False Labor

Question:
When is a woman who presents to triage with uterine contraction deemed stable?

a) The infant and the placenta are delivered
b) Labor contractions are gone
c) It is certified that the woman is in false labor
d) All of the above
Errors and Mistakes

- **Individual**
  - Assessment
    - Missed diagnosis
    - Improper disposition: to: ED, Home,
    - Not timely
    - Handoffs

- **System**
  - Long waits
  - Crowding
  - Delays in consulting
  - EMR
  - Handoffs
Recognizing active labor and transfer of pregnant woman with high risk fetus

Question:
When a woman who presents to triage with uterine contraction and fetus with a cardiac anomaly?

a) Admit - plan for delivery, notify Pediatrician/Neo
b) Admit - Notify Peds, Consult MFM, consider transfer
c) Don’t admit – transfer woman to Tertiary Care
d) Have her partner drive her to Tertiary Care – it’s faster
COMMITTEE OPINION

• Number 667 • July 2016

• Hospital-Based Triage of Obstetric Patients

• Obstetric units are urged to collaborate with emergency departments and hospital ancillary services, as well as emergency response systems outside of the hospital, to establish guidelines for triage of pregnant women.

• Recently developed, validated obstetric triage acuity tools may improve quality and efficiency of care and guide resource use, and they could serve as a template for use in individual hospital obstetric units.
AWHONN

Based on info from AWHONN’s Perinatal Leadership Summits and AWHONN Perinatal Staffing Data Collaborative:

• Identified need for stringent and consistent triage guidelines for pregnant women and their fetuses

• AWHONN’s Obstetric Triage Science Team:

  ➢ Developed the Maternal-Fetal Triage Index
    1. Support training specific to triage
    2. Monitor nursing care during triage

• Recommendations for quality improvement audits will be included as a component of the online resources to be released. The audit tools will serve as the foundation for additional obstetric triage NCQ measures development.
AWHONN: Measure 01
Triage of a Pregnant Woman

# of pregnant patients and their fetus(es) presenting to L&D for an unscheduled evaluation triaged w/i 10 minutes....

# of all pregnant patients presenting to L&D for an emergency condition
AWHONN: Triage Goal

100% of pregnant patients who present to L&D reporting a real or perceived problem, or are in an emergency condition will be triaged by an RN, Midwife, or MD within 10 minutes.
Priority: Based on the AWHONN MFTI

Question:
How often would you say this is achieved in your department?

a) > 95%
b) 80 - 95 %
c) <80%
d) <50%
e) Not sure – No one audits or reports on this
Fetal Monitoring

a) Priority 1
b) Priority 2
c) Priority 3
d) Priority 4
e) Priority 5
Fetal Monitoring

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Placental Abruption

- Premature separation of a normally implanted placenta
- Occurs in 1% of all births
- Abruption is a leading cause of antepartum hemorrhage

Oyelese Y et al 2006
Management of Placental Abruption

- Management based on **fetal status** and **labor status**

- Initial evaluation should include:
  - Kleihauer-Betke Test?
    - if RH negative → administer RhoGAM
  - Continuous fetal monitoring
  - Large bore IV, Type and crossmatch
  - Foley catheter??

- If the etiology is not trauma or cocaine, watch B/P, **pre-eclampsia** is the next leading cause of abruption
Question: What needs to be done

A. Stat page Obstetrician for immediate bedside evaluation
B. Call for additional RN help and begin intrauterine resuscitation interventions begin to prepare for possible STAT C/S
C. Start a large bore IV, send CBC, Type & Screen
D. All of the above
E. All of the above plus add coagulation panel to lab tests
Decreased Fetal Movement

- G4P2012 arrived from after MD heard audible decel in office
- Hx 2 prior C/S (1)Breech, (2) Repeat, GDM with 2nd pregnancy
- 16:05 – MD requested to bedside. 16:06 MD at bedside
Timely Intervention of non-Category 1

Assessment of intrapartum FHR tracing

- Category I
  - Routine management
- Category II*
  - Evaluation and surveillance
    - FHR accelerations or moderate FHR variability
      - Continue surveillance + Intrauterine resuscitative measures
    - Absent FHR accelerations and Absent/minimal FHR variability
      - Intrauterine resuscitative measures
      - If not improved or FHR tracing progresses to Category III, consider delivery
- Category III
  - Prepare for delivery + Intrauterine resuscitative measures
  - If not improved, consider prompt delivery

*Given the wide variation of FHR tracings in Category II, this algorithm is not meant to represent assessment and management of all potential FHR tracings, but provide an action template for common clinical situations.

1 See Table 2 for list of various intrauterine resuscitative measures
2 Timing and mode of delivery based on feasibility and maternal–fetal status
Decreased Fetal movement

- Prioritized ahead of women that present with non-emergent issues
- Immediately place patient on the monitor
- If no FHT’s, notify MD immediately
- Obtain U/S machine - check for cardiac activity
- If fetal heart rate present, begin NST
- If FHR tracing is abnormal initiate intrauterine resuscitative measures in triage
  - IV Fluids, O2, reposition, tocolytics, prepare for C/S
- If non reactive NST
  - Consider extended monitoring
  - complete AFI/BPP before DC home
Literature Review

- Focus on advanced practice nurse models
- Limited regarding staff RN in triage

Obstetric Triage: Objectives

- Compare and contrast medical-legal implications of telephone and outpatient triage care

- Determine the **right time** for a woman to transition from her home to the hospital for birth
  - **5-1-1 rule** (5 minutes apart, lasting 1 minute, for 1 hour
  - Recent recommendations 4-1-1 or even 3-1-1 (Lamaze Intl.)

- Explore verbal and written **discharge to home instructions**
  - Most women report they feel most comfortable at home
    - Freedom of movement
    - Able to do things for themselves
UCSF False Labor Exceptions for Admission

- Patient offered to walk for 2 hours and cervix rechecked to see if labor is progressing
- Reactive NST and patient is stable they can go home and return when labor is more active
- Patient/partner is given more comfort support instruction by nurse on positions and activities that promote laboring at home
- Prodromal labor:
  - Patient is admitted if agreeable to be augmented with Pitocin or misoprostil
  - Offered pain management with morphine and Phenergan cocktail encouraged to go home and return when labor more active
Multiple Functions of OB Triage Units

- Labor assessment and evaluation
- Decompression of labor and delivery
- Use as a holding area (busy L&D)
- Fetal evaluation and assessment
- Evaluation of medical/ OB complaints (after hours)
- Initial stabilization of OB complications
- Evaluation of OB referrals /transfers
- Triage OB telephone calls
- Selected OB procedures
- Source of OB care when normal source isn’t accessible or available
Hospital Triage: Review Assessments & Interventions

- Labor Evaluation
- ROM
- Contraction pattern
- Frequency/ Intensity
- Discomfort in lower abdomen, back, and groin
- Does activity effect or \( \downarrow \) UC’s
- Cervical change
- Latent phase
  - Long contraction phase
  - Sedation decreases or stops contractions
  - Bloody Show usually not present
True v/s False Labor Status

- Onset of labor is established by observing progressive cervical change
- Two or more cervical exams, separated by adequate time
  - Conflicts between patient perception and the nurses definition of labor
  - Nurses are a valuable source of information and support

Powers, Passage, Passenger and: Personality

- Coping Skills
- Learning Style
- Pain Management
- Patient Education and preparation
**Toolkit:** Implement Early Labor Supportive Care Policies and Active Labor Criteria for Admission

- Translation: Early labor at home. Let labor start on its own!

- **Physiologic onset of labor is critical to the success in labor,** and introduces moms and babies to protective hormonal pathways

- Women admitted in early labor are more likely to have a cesarean, and more likely to have routine interventions e.g. oxytocin even if not clinically necessary
Toolkit: Early admission support

- Admission policy or checklist for spontaneous labor
- Latent labor support and therapeutic rest policies
- Patient education materials to explain rationale for delayed admission, reduce anxiety and provide guidance on when to return to the labor and delivery unit
- Material with specific guidance for partners and family members as to how to best support the woman in early labor
The Toolkit is Aligned with the ACOG/SMFM Consensus Statement and the AIM Patient Safety Bundle

- Readiness
- Recognition and Prevention
- Response to Every Labor Challenge
- Reporting

SAFE REDUCTION OF PRIMARY CESAREAN BIRTHS: SUPPORTING INTENDED VAGINAL BIRTHS

### READINESS

**Every Patient, Provider and Facility**

- Build a provider and maternity unit culture that values, promotes, and supports spontaneous onset and progress of labor and vaginal birth and understands the risks for current and future pregnancies of cesarean birth without medical indication.
- Optimize patient and family engagement in education, informed consent, and shared decision making about normal healthy labor and birth throughout the maternity care cycle.
- Adopt provider education and training techniques that develop knowledge and skills on approaches which maximize the likelihood of vaginal birth, including assessment of labor, methods to promote labor progress, labor support, pain management (both pharmacologic and non-pharmacologic), and shared decision making.

### RECOGNITION AND PREVENTION

**Every Patient**

- Implement standardized admission criteria, triage management, education, and support for women presenting in spontaneous labor.
- Offer standardized techniques of pain management and comfort measures that promote labor progress and prevent dysfunctional labor.
- Use standardized methods in the assessment of the fetal heart rate status, including interpretation, documentation using NICHD terminology, and encourage methods that promote freedom of movement.
- Adopt protocols for timely identification of specific problems, such as herpes and breech presentation, for patients who can benefit from proactive intervention before labor to reduce the risk for cesarean birth.
**Newer Data**

![Graph showing the comparison between Friedman labor curves and the pattern of cervical dilation.](image)

**FIGURE 36-1** Comparison between Friedman labor curves and the pattern of cervical dilation. (Data from Zhang J, Troendle J, Yancey MK: Reassessing the labor curve in nulliparous women. Am J Obstet Gynecol 187:824, 2002. Printed with permission from CV Mosby.)

What UCSF patients are doing

- Walk
- Go home with discharge instructions – (See UCSD handout)
  - What does early labor feel like
  - What can I do for comfort in early labor
  - What should I eat/drink in early labor
  - What can I do if I need more help coping with early labor
  - When should I call or come back into the hospital
Resources to Support Normal Birth

Keep Calm and Labor On!

Know what to expect in early labor

- Oh baby! You just had your first contraction. Is this it? Should you grab your birthing bag and head out?
- You may be in early labor — the phase that comes before active labor.

WHAT HAPPENS IN EARLY LABOR?
- Oh baby! You just had your first contraction. Is this it? Should you grab your birthing bag and head out?
- You may be in early labor — the phase that comes before active labor.

- WHAT HAPPENS IN EARLY LABOR?
  - Children’s benefits to staying home during labor as long as possible:
  - Helps reduce the risk of medical interventions
  - Helps increase the labor hormone, oxytocin — which assists the cervix to thin and open.

HOW CAN YOUR PARTNER OR DoulA SUPPORT YOU?
- Helps reduce the risk of medical interventions
- Helps increase the labor hormone, oxytocin — which assists the cervix to thin and open.

STAY COMFORTABLE BY:
- Resting and relaxing
- Doing plenty of passive walking to your body.
- Going for a walk.
- Focusing on your breathing.
- Eating a regular diet of nutritious food.
- Taking as much time as possible for the delivery.
- Asking your partner or doula for help.

GET THE 4-1-1 ON WHEN TO GO!
- Active labor begins when contractions are roughly 3-5 minutes apart, last 1 minute and have been that way for 1 hour.
- However, listen to your body! If you feel it's time to go to your birthing facility, follow that instinct and/or visit your care provider first especially if your water breaks.

Learn more about early labor in a Lamaze class, in-person or online, so you can be prepared.

© Penny Simkin
- Intimate support
  - partner and/or doula
- Ambulation
  - position changes
  - birth ball
  - yoga mats
- Rebozo
- Therapeutic shower
  - Tub bath
- Acupressure, massage
- Rocking Chair
- Nutritional support
Coping with Labor Algorithm

Observe for cues on admission and throughout labor. Assessment per protocol:

- Ask: "How are you coping with your labor?"
- Every shift - PRN - At signs of change.

**Coping**

- Physiologic/Natural process of labor:
  - Patient desires pharmacological intervention
    - IV pain med [L]
    - Epidural [S]
    - Nitrous Oxide [I]
  - Patient desires non-pharmacological intervention
    - Interventions as to what would give best relief and is indicated (what does the patient desire):
      - Tub/bath/shower [S]
      - Hot pack/cool pack [I]
      - Water injections
      - Massage/foreplay
      - Movement/embulbination/position changes [S]
      - Birth ball
      - Focus points
      - Breathing techniques
      - Acupuncture
      - Self-hypnosis [S]
      - TENS

- Follow:
  - Unit
  - Service line
  - Hospital
  - Guidelines/standards for pharmacological intervention

**Physical Environment**

- Appropriate changes to environment PRN [S]
  - Mood [*]
  - Lighting [*]
  - Music [*]
  - Fragrance [*]
  - TV/Move [*]
  - Temperature [*]
  - Whispering voices [*]

**Emotional/Psychosocial**

- One-on-One Support [S]
- Doula [S]
- Midwifery Care being "With Woman" [S]

- The nurse should consider:
  - Patient's life
  - Sexual abuse
  - Fear
  - Stress
  - Interpersonal dynamics

- Offer social work consult

**Legend**

[S] = Sufficient Evidence
[L] = Limited Evidence
[I] = Insufficient Evidence
[*] = No Evidence & No Harm

**Not Coping**

- Cues you might see if woman is NOT coping (May be seen in transition):
  - States she is not coping
  - Crying (May see with self-hypnosis)
  - Sweaty
  - Transluscent voice
  - Thrashing, wincing, writing
  - Inability to focus or concentrate
  - Clawing, biting
  - Panicked activity during contractions
  - Tense

- Reassessment

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EPIC: Coping verses Not-coping IN LABOR!
EPIC: Coping verses Not-coping IN LABOR!
Appendix M
Spontaneous Labor Algorithm

If Maternal or Fetal Medical Indication for Admission: DO NOT USE THIS ALGORITHM

Triage

- Spontaneous Labor
- Intact membranes
- Stable Mother and Baby
- Term, Singleton, Vertex (TSV)

Cervix less than 4 cm

Home

Walk and Reassess

For Induction of Labor: See Induction Algorithm (if enters active phase, follow arrow)

Cervix ≥ 4 cm & in Labor.

*Note: special circumstances such as severe fatigue, multiple triage visits, prolonged latent phase, and difficulty coping may warrant admission before 4 cm.

Admit to L&D

Inadequate Progress First Stage

Depending on assessment; Home, AROM and/or Oxytocin, or Cesarean

(ACOG criteria for Arrest of Labor: at least 6 cm dilation with ruptured membranes, AND at least 4 hours of adequate contractions without cervical change OR 6 hours of oxytocin with inadequate contractions and no cervical change)

Inadequate Progress Second Stage

AROM and/or Oxytocin if not already done

Operative Delivery or Cesarean Delivery

(ACOG criteria for 2nd Stage Arrest: at least 3 hours of pushing for nulliparas, at least 4 hours of pushing for nulliparas with epidural, at least 2 hours of pushing for multiparas, at least 3 hours of pushing for multiparas with epidural)

Adequate Progress

Vaginal Delivery

Inadequate Progress

Vaginal Delivery

Adequate Progress

CMQCC Toolkit to Support Vaginal Birth and Reduce Primary Cesareans

Adapted with permission from Washington State Hospital Association
Discharge for latent phase

- Eat easily digested foods, drink plenty of fluids
- Alternate activity with rest and take nice walks
- Prepare last minute things for baby
- Surround yourself with people that help you feel comfortable
- Relax with a warm shower
- Listen to music to maintain a tranquil environment
- Ask your partner for a massage
- If unable to talk during a contraction begin a slow chest breathing pattern
- Listen to your body and follow your instinct when it’s time to come back to the hospital
Therapeutic rest

- Protocol
- Morphine Phenergan dosing
- Trial in progress
Resources
Impact of Collaborative Management and Early Admission in Labor on Method of Delivery

• Prospective study (2,196)
  • Fewer (23.4%) admitted in labor <4 cm when co-managed with midwife
  • Women admitted in early labor (<4 cm) had fewer vaginal deliveries

• Conclusion: Later admission in labor (>4 cm) and collaborative care MD/CNM increased rate of NSVD
Improving Satisfaction with Care and Reducing Length of Stay in an Obstetric Triage Unit Using a Nurse-Midwife-Managed Model of Care

Paul, J., et al. (2013) *Journal of Midwifery & Women’s Health*

- A QI project in a north east tertiary-care hospital in US
  - Shorten length of stay / improve patient satisfaction
    - Comparative design: Standard Care v/s CNM Model
    - 272 Women: 121 Standard care – 151 CNM Model
    - Measured with validated questionnaire
      - based on Molloy and Mitchell, BJM 2010
Women in the CNM managed group were significantly more likely to be extremely satisfied with 5 of 6 aspects measured:

1. Wait time for provider
2. Time spent with provider
3. Length of visit
4. Overall care received
5. Overall triage experience
ESTABLISHING PHONE TRIAGE

- EDUCATION
- COMPETENCY
- DOCUMENTATION
## Phone Triage

**Question:**

Does your Department have a formal phone triage policy and procedure?

- a) No we instruct the patient to call their doctor
- b) No but we informally guide them over the phone
- c) Yes formal P&P with written documentation
- d) Not sure – we’re kind of “winging it” no formal training
- e) Other
Phone Triage for Labor

Department guideline?

Gestational age
Complications of pregnancy
ROM
Mucous/Bloody Show
Uterine activity
Recent cervical exam
Fetal Movement
Assess stay home & call back or come in
Notify MD / CNM

“Welcome policy”
Competence Assessment

- L&D Nurses must complete a series of competence assessments with qualifying exams
  - This education material was based on current evidence and practice standards
  - Emphasis on triage as a systematic approach to rapid patient assessment
  - Assigns priority on the degree of need
  - Primary goal for triage nurse to assign acuity within 10 minutes of arrival to the unit
- Once the educational requirements the nurse is deemed “Triage competent”
BASIC CONSIDERATIONS IN ESTABLISHING A TELEPHONE TRIAGE SYSTEM

1. Are “Protocols” or “Guidelines” an Appropriate Format?
2. What's the First Step in Drafting Protocols or Guidelines?
3. Who Should Handle the Calls?
4. How Should Calls Be Documented?
5. What Information Is Pertinent for Each Patient Who Calls?
6. Health Insurance Portability and Accountability Act (HIPAA)
   • Speak to the patient, check MR for authorization, confidential record
7. Reducing legal risks/improving patient care
   • Adequately trained staff, protocols in writing, proper documentation

Telephone Triage for Obstetrics and Gynecology, 2010. Philadelphia
Vicki E. Long MSN, CNM, RN, Patricia C. McMullen PhD, JD, WHNP-BC, RN
UCSF
Perinatal Telephone Triage Record

Current Pregnancy Medical Complications:
- None
- PTL
- HTN
- GDM
- Breech
- Previous C/S
- Twins
- Hyperemesis

Assessment: R/O PTL, SROM, Preeclampsia ...

Disposition/ Plan
Instructions to patient – come in, stay home, when to call back
F/U from patient, document date and time
UCSF Telephone Triage

- Staff Nurse Patsy Creedy RN, BSN
- Provides triage education to select L&D staff
  - Definition and History
  - Who Calls
  - What Do They Call About?
  - Johnson and Johnson Study (1990)
- May eliminate unnecessary trips to the hospital
- Informational
UCSF OB Phone Triage:
3 Recommendations

1. Only Triage trained RN's can answer calls
2. Use standardized phone interview
3. Discussion, Disposition, and Documentation
UCSF OB PhoneTriage: Medical Legal Aspects

- American College of Emergency Physicians recommends against diagnosis or treatment by phone
- When in doubt, go to ED or L&D
- Ok to respond to D/C questions-instructions, meds, referrals, first-aid info
- Advice given only by qualified medical professionals
- Quality assurance-policies, protocols, documentation, to monitor outcomes
- Controversy exists over legal parameters
UCSF OB TRIAGE: Accountability

- Conscientious use of department guidelines
- Complete documentation
- Adherence to standards
- Quality assurance guidelines
UCSF OB TRIAGE: Standard of Care

The level of care that would be given by a reasonably prudent nurse under the same or similar circumstances
UCSF OB TRIAGE:
Elements of Negligence

- Duty to behave reasonably
- Negligence - failure to act reasonably AND results in injury
- Must provide proof that the person accused failed to act reasonably when they had a duty to do so
- The failure to act reasonably caused an injury related to the breach of duty
- When a nurse fails to do what a reasonably prudent nurse would do under similar circumstances, the standard of care is considered breached
UCSF OB TRIAGE: Duty to Terrify

• Tennenhouse 1988
  • “Duty to terrify is a duty based on the liability from an injury to the noncompliant patient who claims that his or her noncompliance was due to an inadequate understanding of the urgency of the situation.”

• Nurses must err on the side of caution when in doubt

• Directives should be specific enough to convey urgency

http://teletriage.com
UCSF OB Phone Triage: Working Diagnosis

- Neither MD’s or RN’s can diagnose without an exam
- Acceptable to form initial impressions “working diagnosis”
- Identify symptoms and classify by acuity rather than seeking to determine specific causes of symptoms
- The MD or RN must always inform patient of the presumptive status of this evaluation
- Use language the client can understand
UCSF OB Phone Triage: Communication

Goal of Telephone triage:

• Listen - receive information
• Assess - acute verses non-acute
• Give and receive information
• Release anxiety - inspire, persuade engender trust
• Problem solve
UCSF OB TRIAGE: Effective Telephone Technique

- Good communication depends on receiving information as much as on sending it
- The manner of communication is almost as important as what is communicated
- Inspires, persuades, engenders trust
UCSF OB Phone Triage: Telephone Charisma

- Self disclosure
- Empathy
- Respect
- Warmth
- Authenticity
- Compassion
UCSF OB Phone Triage: Respecting the Patient

- Allow enough time
- Open-ended questions
- Create a safe, understanding atmosphere
- Do not patronize the patient or belittle the problem
- Patient satisfaction can build patient independence and foster additional learning
UCSF OB Phone Triage: Common Practice Errors

- Using leading questions
- Using medical jargon
- Inadequate data collection
- Stereotyping patients or problems
- Failure to talk directly to the patient
- Patient self-diagnosis and second guessing
- Don’t devalue reassurance calls
UCSF OB TRIAGE: Three Stages of a Triage Call

- **Stage One: Gathering Data**
  - Spend at least 2-3 minutes gathering data
  - Active listening vs. passive listening
  - Open-ended questions vs. leading questions

- **Stage Two: Confirmation**
  - Clarify
  - Reiterate
  - Formulate a working diagnosis

- **Stage Three: Disposition**
  - Classify the problem
  - Provide protocol advice
  - Make a plan
  - Ask patient if they have any more questions
  - Have patient reiterate instructions/plan when necessary
Phone Triage for Term Labor

- Janssen, Still, Klein, et al. (2006). University of British Columbia, Canada
  Early labor assessment and support at home versus telephone triage: a randomized controlled trial. Obstetrics and gynecology, 108(6), 1463-1469.
  LEVEL OF EVIDENCE: I

- 731 women were managed by a telephone triage nurse
- 728 women received a home visit
- C/S Rates
- Narcotic, epidural analgesia → no statistic significance
- Augmentation of labor
- Significantly fewer women were admitted < 3 cm’s
- Significantly more women managed their labor without a visit to the hospital for assessment
- What about Costs?
Case Presentation

- 05:20 Ms. Davis is admitted to L&D as an outpatient - (out of network)
- 36 yo G4 P2 at 35+3 weeks gestation
- C/O upset stomach and pain around diaphragm
- VS: 98.6, HR 68, R 18, BP 161/85, re√ 140/84,
  - Pain 7-8/10
- FHR tracing on L&D 05:30 – 07:33
- Baseline 140, Moderate variability, accelerations to 165 no decelerations noted (Category I)
How did this happen?

Defenses

- Culture
- Policies
- Resources
- Training
- Communication

Failures

- Safeguards
- Stop the line
- Standard work
- Flexible staffing
- Self-checks
- Harm

UCSF Benioff Children’s Hospitals
Question: What is the recommended time to wait to confirm severe range BP in Triage

A. 5-10 minutes
B. 15 minutes
C. 30 minutes
D. 1 hour

E. You must have 2 BP measurements 4-6 hours apart to diagnose Preeclampsia with severe features
How to Accurately Measure Blood Pressure

- Patient seated comfortably, legs uncrossed, back and arm supported
- Use the correct sized cuff so that it **fits correctly** around the upper arm and line the middle of the BP cuff with the level of the right atrium (middle of the sternum)
- Patient should be **relaxed** and instructed **not to talk** during the measurement
  - Ideally a resting time of several minutes should elapse before the BP is taken

- If initial assessment elevated
  - Repeat after several minutes to determine if hypertension persists

ACOG, 2013; CMQCC, 2013
### Diagnostic Criteria

**TABLE E-1. Diagnostic Criteria for Preeclampsia**

| Blood pressure | • Greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic on two occasions at least 4 hours apart after 20 weeks of gestation in a woman with a previously normal blood pressure  
• Greater than or equal to 160 mm Hg systolic or greater than or equal to 110 mm Hg diastolic, hypertension can be confirmed within a short interval (minutes) to facilitate timely antihypertensive therapy  

and

| Proteinuria | • Greater than or equal to 300 mg per 24-hour urine collection (or this amount extrapolated from a timed collection)  

or

• Protein/creatinine ratio greater than or equal to 0.3*  
• Dipstick reading of 1+ (used only if other quantitative methods not available)  

Or in the absence of proteinuria, new-onset hypertension with the new onset of any of the following:

| Thrombocytopenia | • Platelet count less than 100,000/microliter  

| Renal insufficiency | • Serum creatinine concentrations greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease  

| Impaired liver function | • Elevated blood concentrations of liver transaminases to twice normal concentration  

| Pulmonary edema |  

| Cerebral or visual symptoms |  

* Each measured as mg/dL.
**Severe Features of Preeclampsia**

<table>
<thead>
<tr>
<th>BOX E-1. Severe Features of Preeclampsia (Any of these findings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Systolic blood pressure of <strong>160 mm Hg</strong> or higher, or diastolic blood pressure of <strong>110 mm Hg</strong> or higher on two occasions at least 4 hours apart while the patient is on bed rest (unless antihypertensive therapy is initiated before this time)</td>
</tr>
<tr>
<td>• Thrombocytopenia (platelet count less than 100,000/microliter)</td>
</tr>
<tr>
<td>• Impaired liver function as indicated by abnormally elevated blood concentrations of liver enzymes (to twice normal concentration), severe persistent right upper quadrant or epigastric pain unresponsive to medication and not accounted for by alternative diagnoses, or both</td>
</tr>
<tr>
<td>• Progressive renal insufficiency (serum creatinine concentration greater than 1.1 mg/dl or a doubling of the serum creatinine concentration in the absence of other renal disease)</td>
</tr>
<tr>
<td>• Pulmonary edema</td>
</tr>
<tr>
<td>• New-onset cerebral or visual disturbances</td>
</tr>
</tbody>
</table>

ACOG, 2013, Htn in Pregnancy, p. 3
Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period
Antihypertensive Medications

SBP ≥ 160 OR DBP ≥ 105-110?

- Medications should be given NO MORE than 1 hour after presenting in hypertensive emergency*
  - Aim for no more than 30 minutes
- This is the biggest step in decreasing morbidity and mortality
- Aim to return BP to a range where intracranial hemorrhage not a risk, but not to normal range
  - Goal: 140-160/90-100

*Hypertensive emergency: acute-onset, severe hypertension that persists for ≥ 15 minutes
Anithypertensive Medications

First Line Agents

<table>
<thead>
<tr>
<th></th>
<th>IV Labetalol</th>
<th>IV Hydralizine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose (IVP over 2 minutes)</td>
<td>20 mg</td>
<td>5-10 mg</td>
</tr>
<tr>
<td>Onset</td>
<td>2-5 minutes</td>
<td>5-20 minutes</td>
</tr>
<tr>
<td>Peak</td>
<td>5 minutes</td>
<td>15-30 minutes</td>
</tr>
<tr>
<td>24 hour max</td>
<td>220 mg</td>
<td>25 mg</td>
</tr>
</tbody>
</table>

** If no IV access, PO nifedipine should be used
- Nifedipine PO 10 mg may repeat in 30 min
- Onset: 5-20 min
- Peak 30-60 min
# Maternal Early Warning Criteria

<table>
<thead>
<tr>
<th>Measure</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic Blood Pressure (mm Hg)</td>
<td>&lt;90 or &gt;160</td>
</tr>
<tr>
<td>Diastolic Blood Pressure (mm Hg)</td>
<td>&gt;100</td>
</tr>
<tr>
<td>Heart rate (beats per minute)</td>
<td>&lt;50 or &gt;120</td>
</tr>
<tr>
<td>Respiratory rate (breaths per min)</td>
<td>&lt;10 or &gt;30</td>
</tr>
<tr>
<td>Oxygen saturation on room air, at sea level %</td>
<td>&lt;95</td>
</tr>
<tr>
<td>Oliguria, mL/hr for ≥2 hrs</td>
<td>&lt;35</td>
</tr>
<tr>
<td>Maternal agitation, confusion, or unresponsiveness</td>
<td></td>
</tr>
<tr>
<td>Woman with preeclampsia reporting a non-remitting headache or shortness of breath</td>
<td></td>
</tr>
</tbody>
</table>

The Maternal Early Warning Criteria: A Proposal From the National Partnership for Maternal Safety.

Mhyre, Jill; DOria, Robyn; MA, RNC; Hameed, Afshan; Lappen, Justin; Holley, Sharon; CNM, DPN; Hunter, Stephen; MD, PhD; Jones, Robin; King, Jeffrey; DALton, Mary
Maternal Early Warning Systems

- Abnormal physiologic signs and symptoms precede critical illness
- Early intervention will avoid severe M&M occurrence
- Effective policy of escalation of care

Nip it in the bud
What about this position?

“Her blood pressure was elevated when she first presented to triage but I had her rest on her side to cycle her blood pressures and all other measurements have been within normal limits”
**READINESS**

**Every Unit**
- Standards for early warning signs, diagnostic criteria, monitoring and treatment of severe preeclampsia/eclampsia (include order sets and algorithms)
- Unit education on protocols, unit-based drills (with post-drill debriefs)
- **Process for timely triage and evaluation of pregnant and postpartum women with hypertension including ED and outpatient areas**
  - Rapid access to medications used for severe hypertension/eclampsia: Medications should be stocked and immediately available on L&D and in other areas where patients may be treated. Include brief guide for administration and dosage.
  - System plan for escalation, obtaining appropriate consultation, and maternal transport, as needed

**RECOGNITION & PREVENTION**

**Every Patient**
- Standard protocol for measurement and assessment of BP and urine protein for all pregnant and postpartum women
- Standard response to maternal early warning signs including listening to and investigating patient symptoms and assessment of labs (e.g. CBC with platelets, AST and ALT)
- Facility-wide standards for educating prenatal and postpartum women on signs and symptoms of hypertension and preeclampsia
RESPONSE

Every case of severe hypertension/preeclampsia

- Facility-wide standard protocols with checklists and escalation policies for management and treatment of:
  - Severe hypertension
  - Eclampsia, seizure prophylaxis, and magnesium over-dosage
  - Postpartum presentation of severe hypertension/preeclampsia

- Minimum requirements for protocol:
  - Notification of physician or primary care provider if systolic BP =/> 160 or diastolic BP =/> 110 for two measurements within 15 minutes
  - After the second elevated reading, treatment should be initiated ASAP (preferably within 60 minutes of verification)

- Includes onset and duration of magnesium sulfate therapy
- Includes escalation measures for those unresponsive to standard treatment
- Describes manner and verification of follow-up within 7 to 14 days postpartum
- Describe postpartum patient education for women with preeclampsia
- Support plan for patients, families, and staff for ICU admissions and serious complications of severe hypertension

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of all severe hypertension/eclampsia cases admitted to ICU for systems issues
- Monitor outcomes and process metrics

Note: “Facility-wide” indicates all areas where pregnant or postpartum women receive care. (E.g. L&D, postpartum critical care, emergency department, and others depending on the facility).
Rule Out Preeclampsia

- Clean catch urine ➔ 24 hr urine protein collection
- BP Q 10 minutes
- NST X 30 minutes or longer
- Labs-CBC, Plts, AST, Protein /Creatinine ratio
- Ask pt about changes in vision, epigastric pain, or headache
- Note swelling, DTR’s
The Importance of Interdepartmental Collaboration and Safe Triage for Pregnant Women in the Emergency Department
Chagolla, B et al. (2013) JOGNN

- Population changes
  - Diabetes
  - Hypertension
  - Obesity
  - No prenatal care
The Importance of Interdepartmental Collaboration and Safe Triage for Pregnant Women in the Emergency Department
Chagolla, B., et al. (2013) JOGNN

- 30 Dignity Health Hospitals
- Describes a triage model for evaluation of pregnant women in the ER
- Standardize Care
- Clear policies and procedures
- Interdepartmental communication
- UCSF case
HOSPITAL TRIAGE

✓ STAFFING
✓ ASSESSMENT
✓ GUIDELINES
Hospital Triage: Assessments & Interventions

**Initially**
- Maternal VS, FHR, and UC’s

**Further Evaluation**
- Vaginal bleeding
- Acute pain
- Fever
- Preterm
- Hypertension
- Indeterminate or abnormal FHR tracing

If these findings are present the responsible obstetric-care provider should be promptly informed.

Hospital Triage:
Common Scenarios

- Decreased Fetal movement
- Rule Out Labor
- Rule Out Abruption (s/p MVA)
- Rule Out Preeclampsia
- Rule Out Premature rupture of Membranes
- Rule Out SAB or Ectopic
- Rule Out Hyperemesis
- Sexually Transmitted Disease
- Urinary Tract Infection
- Asthma
- Version
- Amniocentesis
- Wound Checks
Clinical Presentation:
Generalized Broad Complaints

- Pain
  - Abdominal
  - Epigastric
  - Broad Ligament
  - Back
  - Headache
- Gastrointestinal
  - Vomiting
  - Nausea
  - Diarrhea
- Respiratory
  - Shortness of Breath

One of the most difficult aspects of OB Triage is managing conflicting symptomatology.

- History
- Physical Assessment
- Lab results
- U/S
- CT
- MRI

Angelini et al., (2005) Journal of Midwifery and Women’s Health
Initial Assessment of Preterm Labor

- Health history - suspicion
- Reproductive history – be careful
- Appropriate physical exam (Targeted) - VS
- Prenatal course of current pregnancy (record)
- Determine accurate gestational age
- Routine obstetric clinical parameters
- Describe signs/symptoms of PTL
- Education of woman and support system
Hospital Triage: Preterm Labor
Assessments & Interventions

Concise MD order set: Tocolysis, Neuroprotection
• Clean catch urine specimen
• HOB ↑ 20-30 degrees - lateral decubitus position
• Vital Signs and current weight
• Obtain History
• Assess hydration status
• EFM monitoring / fetal assessment: notify Peds
• Sterile Speculum procedure: notify MFM
  • GBS Procedure
  • Fetal fibronectin
  • Amnisure™ testing
• Vaginal U/S → cervical length
• Betamethasone
• Nursing Competencies
  • Sterile speculum exam
  • Amnisure™ testing
  • Fern testing
Periviable Birth: 20+0/7 - 25+6/7
extreme preterm, micro preemie, threshold of viability

- survival rates in general (variance)
  - 0% @ 20 weeks
  - 50% @ 25 weeks

- An overview of survival and morbidity

- The possibility of long-term neurological and neurodevelopmental problems

- The possibility that expectations for the baby may change after birth depending on the condition of the newborn

In general, tocolytics are not indicated for use before neonatal viability and no data exists regarding the efficacy of corticosteroid use before viability

ACOG Practice Bulletin Number 171 October 2016
OB Trauma s/p MVA: Rhogram? KB?
Rule Out Abruption

• If vaginal bleeding
  – NST/toco
  – Place IV
  – Labs: CBC, T&S, PT/PTT

• If Ø vaginal bleeding
  • NST/toco
  • Place IV
  • Labs: CBC, T&S, PT/PTT
  • Minimum 4-6 hrs observation

Angelini et al., (2005) Journal of Midwifery and Women’s Health
ACOG educational bulletin. Obstetric aspects of trauma management. Number 251
ALL information needs to be placed somewhere on a written or computerized chart.

- Lab results
- Fetal test results
- Fetal status
- Conversations with consultants – recommendations
- Interventions performed
- Plan of care
- Follow-up plans
- Instructions – verbal, written
- Patient understanding
Committee was formed in 2007 to explore
• how obstetric triage was occurring
• develop a better triage process
Committee members included
• triage nurses, perinatal educators, nurse managers, risk managers, nursing administrators.

4 Hospital sites were observed and evaluated for their triage process and practice. The following inconsistencies were identified:

Nurses cared for women in order of arrival, rather than by triage acuity.

The time the patient’s first encounter with a triage nurse should be used as the time the acuity is assigned;

no current valid and reliable obstetric triage tools were found
Based on Manchester Triage Group
  • a five-tier system as a evolution over time

Canadian ED Triage and Acuity Scale
  • includes time frames and acuity levels
    – first by nurses, then by the physician
Patient should have Primary OB triage assessment within 10 minutes of arrival.

1 - Immediate

2 – Urgent (Within 15 minutes)

3 – Semi Urgent (30 minutes)

4 – Less Urgent (60 minutes)

- Procedure/ Testing (≤120 min)
Florida Hospital OB Triage Acuity Tool©

Patient should have Primary OB triage assessment within 10 minutes of arrival.

1 - Immediate

- Airway
- Breathing
- Circulation

} \( \text{Resuscitative} \)

- Respiratory Distress
- Chest pain
- Trauma
- Hemorrhage
- Presenting fetal parts
- Prolapsed umbilical cord
- Impending Delivery
- Seizing

2 – Urgent (*Within 15 min)

- R/O LABOR
  - Active labor
  - Regular contractions
    - ≤ 5 mins apart
  - Severe pain (≥7 on scale)
- PRETERM (20–30 6/7 weeks)
  - Backache, Contractions, Tightening “Cramping”
  - Spotting, Rupture of Membranes (R/O ROM)
  - UTI symptoms
- VAGINAL DISCHARGE
  - Heavy blood loss, Passing clots
- FETAL WELL-BEING
  - No fetal movement, Decelerations
- BLOOD PRESSURE
  - Severe preeclampsia, Epigastric pain
  - Blurred vision, Severe Headache, Elevated BP
- MENTAL/PSYCHOSOCIAL
  - Altered conscious level, Suicidal
- OTHER FACTORS
  - History of seizure (within 6 hrs), Alert on arrival
  - Diabetes, Hypoglycemia/ Hyperglycemia
  - Severe Pain (≥7 on scale)
### 3 – Semi Urgent (30 min)

- **R/O LABOR**
  - Irregular contractions
    - >37 weeks
  - Moderate pain
    - (4–6 on scale)
- **VAGINAL DISCHARGE**
  - Spotting” >37 weeks, SROM > 37wks
- **FETAL WELL-BEING**
  - ↓ Fetal Movement,
    - Non-reactive Non-stress Test (NST)
- **BLOOD PRESSURE**
  - BP checks
  - History of high BP
- **MENTAL/PSYCHOSOCIAL**
  - History of suicide attempts
- **OTHER FACTORS**
  - Previous Cesarean in Labor
  - Recent trauma, Falls, MVA
  - Fever/chills, Active Vomiting
  - Moderate Pain (4–6 on scale)

### 4 – Less Urgent (60 min)

- **R/O LABOR**
  - Early labor, Mild irregular contractions
  - Backache > 37 weeks
  - Mild pain (1–3 on scale)
- **VAGINAL DISCHARGE**
  - Bloody show
  - Mucus
  - R/o infection
- **MENTAL/PSYCHOSOCIAL**
  - Non-OB Complaints
  - Insomnia
  - Psychosocial problems
    - not “acting out”
- **OTHER FACTORS**
  - Aches and pains
  - Nausea
  - Hyperemesis
  - Mild Pain (1–3 on scale)
Patient should have Primary OB triage assessment within 10 minutes of arrival.

Procedure/ Testing (≤120 min)

- FETAL WELL-BEING
  - Scheduled NST
  - Biophysical Profile
  - Ultrasound

- OTHER FACTORS
  - Elective/scheduled
    - Cesarean birth
    - Inductions
    - Other procedures
  - Incision check
  - Breech version
  - Injections
    - Betamethasone
Initial contact with the patient to determine acuity. It includes: Name, Physician, Gravida/Parity, Gestational Age, Medical and Obstetrical history, Chief Complaint and Pain Assessment.

**Immediate Treatment/Delivery**
- Complete “ObjectiveFocused Assessment”

**Medical Screening Exam**

**Secondary OB Triage**
- Periodic Reassessment to be done within the time frame set for that acuity. It includes Maternal Vital Signs, Fetal Heart Tones, Pain reassessment and question “Any changes in condition/chief complaint?”

**Disposition**
- Admit
- Observe
- Discharge
Barriers Identified

- The triage committee continues to meet, review data, and identify barriers

Barriers include:

- More than 2 triage patients per triage nurse
- Waiting for tests to be performed/results
- Multiple patients arriving at once
- Triage staff being assigned to other duties

Resolution of Barriers

- Ensure adequate nurse staffing
- Work with ancillary departments to speed the process of obtaining results
Implementing an Obstetric triage acuity scale: interrater reliability and patient flow analysis


- Developed a 5 category Obstetric triage acuity scale (OTAS)

- Explore the possibility of “Fast track”

- Practice change for nurse
  - Avoid informal triage assessment
  - Need to set target times

- **Speculate** implementation of OTAS will:
  - Decrease LOS for low acuity cases
  - Improve secondary assessment by MD for higher acuity cases
### Implementing an Obstetric triage acuity scale: interrater reliability and patient flow analysis

Smithson, D. et al. AJOG (2013)

#### OBCU Obstetrical Triage Acuity Scale (OTAS)

<table>
<thead>
<tr>
<th>OTAS</th>
<th>Level 1 (Resuscitative)</th>
<th>Level 2 (Emergent)</th>
<th>Level 3 (Urgent)</th>
<th>Level 4 (Less Urgent)</th>
<th>Level 5 (Non-Urgent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Secondary Health Care Provider</td>
<td>Immediate</td>
<td>≤ 15 minutes</td>
<td>≤ 30 minutes</td>
<td>≤ 60 minutes</td>
<td>≤ 120 minutes (2 hours)</td>
</tr>
<tr>
<td>Re-assessment</td>
<td>Continuous Nursing Care</td>
<td>Every 15 minutes</td>
<td>Every 15 minutes</td>
<td>Every 30 minutes</td>
<td>Every 60 minutes</td>
</tr>
</tbody>
</table>

#### Labour/Fluid
- Imminent birth
- Suspected preterm labour/PPROM < 37 weeks
- Signs of active labour > 37 weeks
- Signs of early labour/SROM > 37 weeks
- Discomforts of pregnancy

#### Bleeding
- Active vaginal bleeding with/without abdominal pain
- Bleeding associated with cramping (> spotting) < 37 weeks
- Bleeding associated with cramping (> spotting) > 37 weeks
- Spotting

#### Hypertension
- Seizure activity
- Hypertension > 160/110 and/or headache, visual disturbance, RUQ pain
- Mild Hypertension > 140/90 with/without associated signs and symptoms

#### Fetal Assessment
- Abnormal FHR tracing
- No fetal movement
- Atypical FHR tracing, abnormal BPP, abnormal dopplers
- Decreased fetal movement
- Ongoing assessment from outpatient clinic (for hypertension, blood work)
- Minor trauma (minor MVC/fall)
- Nausea/vomiting and/or diarrhea
- Signs of infection (i.e. dysuria, cough, fever, chills)
- Anything that does not seem to pose threat to mother or fetus
- Cervical Ripening
- Outpatient placenta previa protocol
- Pre-booked visits (i.e. Rh and progesterone injections, NST)
- Assessment for version
- Rashes

#### Other
- Acute onset severe abdominal pain
- Altered level of consciousness
- Cord prolapse
- Severe respiratory distress
- Suspected sepsis
- Major trauma
- Shortness of breath
- Unplanned and unattended birth
- Abdominal/back pain greater than expected in pregnancy
- Flank pain/hematuria
- Nausea/vomiting and/or diarrhea with suspected dehydration

Property of London Health Sciences Centre
Obstetric Triage: Staffing

- Multiply 1.2 - 1.5 of overall birth volume
- Requires assessment of mother and fetus
  - “in a timely manner” - not defined by AAP or ACOG
- Care is ongoing until disposition
- The initial triage process (10 - 20) minutes
- Requires 1 nurse to 1 woman presenting for care
- This ratio may be changed to 1 Nurse: 2-3 woman as maternal-fetal status is determined to be stable or until patient disposition is determined
- 1 Nurse to 2-3 women during non-stress testing

Guidelines for Professional Registered Nurse Staffing. AWHONN 2010.
Question:
You have a patient in Triage for a scheduled NST who you just put on the monitor. A new patient arrives and is complaining of not feeling well/headache/maybe has the flu. She’s not feeling any painful contractions and isn’t due for 6 weeks. You check VS: Temp 100.5, HR 118, BP 162/98

What should you do next?
A. Ask her if she can go to the bathroom and give a urine sample
B. Apply FHR Monitor, wait 10 minutes and assess fetal tracing
C. Notify the Obstetrician and request immediate bedside evaluation
D. Call out to the desk for an extra pair of hands
E. C & D
<table>
<thead>
<tr>
<th>Acuity Level</th>
<th>Nurse-to-Patient Ratio</th>
<th>Type of Patient or Clinical Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>2-to-1</td>
<td>Critically ill, hemodynamically unstable</td>
</tr>
<tr>
<td>B</td>
<td>2-to-2</td>
<td>Birth (including 30–60 min during the immediate postpartum recovery period until the critical elements are met for both mother and baby)</td>
</tr>
<tr>
<td>C</td>
<td>1-to-1</td>
<td>Epidural initiation (approximately 30 min); oxytocin induction or augmentation of labor; magnesium sulfate during labor and immediate postpartum; second-stage labor pushing; some indeterminate and all abnormal fetal heart rate patterns; labor in the shower or whirlpool tub (if support person is not available to stay with patient); intermittent auscultation during active labor; morbid obesity such that continuous electronic fetal monitoring is challenging requiring repeated bedside monitoring adjustments</td>
</tr>
<tr>
<td>D</td>
<td>1-to-2</td>
<td>Cervical ripening with pharmacologic agents; spontaneous labor with adequate pain control without pharmacologic agents, or labor epidural or parenteral pain relief resulting in patient comfort</td>
</tr>
<tr>
<td>E</td>
<td>1-to-3</td>
<td>Obstetric triage, rule out labor, nonstress testing, stable antepartum patients, and mother–baby couplets</td>
</tr>
</tbody>
</table>
Current Commentary
The National Partnership for Maternal Safety
Mary E. D’Alton, MD, Elliott K. Main, MD, M. Kathryn Menard, MD, and Barbara S. Levy, MD

Current Commentary
The Maternal Early Warning Criteria
A Proposal From the National Partnership for Maternal Safety
Mhyre, J., D’Oria, R., Hameed, A., et al

Obstetrics & Gynecology
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Obstetrics & Gynecology
VOL. 124, NO. 4, Oct 2014
## YOUR PRACTICE DOMAIN

- Stress
- Fatigue
- High stakes
- Time pressure
- Task saturation
- Auditory overload

- Two patients
- Language barrier
- High expectations
- Limited resources
- Multiple care teams
- Frantic spouse/family
Sentinel Event Analysis

Root Causes

- Communication (72%)
- Staff competency (47%)
- Orientation and training (40%)
- Inadequate fetal monitoring (34%)
- Unavailable monitoring equipment/drugs (30%)
- Credentialing/Privileging/Supervising MD CNM (30%)
- Staffing issues (25%)
- Physician unavailable or delayed (19%)
- Unavailable prenatal information (11%)
The Principles of the Program
Behavioral Skills (CRM)

- Know your environment
- Anticipate and plan
- Assume the leadership role
- Communicate effectively
- Distribute work load optimally

- Allocate attention Wisely
- Utilize all available information
- Utilize all available resources
- Call for help early enough
- Maintain professional behavior
Know Your Environment

- Sounds simple but it’s not!
- Emergency equipment rarely used
  - Portable cardiac monitor, Central Line set-up
- Often there was a small widget needed
  - Suction failure, pentothal pin, stopcock
- Equipment and supplies move
- Staff vacations, relief/float staff
The Gallup Pole Survey (given to UC staff) asked the question:

“I have the materials and equipment I need to do my work right.”

Our score on 15L was 3.32 out of 5.0
- The average score for BCH was 3.68
- UC Med Center was 3.78
- Overall UC system was 3.68

15L staff meeting identified this as an area for improvement. Staff volunteered to help form a committee to improve 15L’s work environment.

I volunteered to Chair the committee to address these issues.

The “Staff Engagement Council-Workflow Committee” was created.
Mission

To improve workflow on the unit for staff to feel they have what they need to do their job— in essence to improve patient safety and staff’s job satisfaction.

- Patient Safety
- Work Environment
- Staff Satisfaction
Instrument & Supply Room
Access to Emergency Instruments

Relocated non-emergent equipment

Unobstructed path to emergency instruments

Reestablished par levels

Emergency instruments/Red Bins
Instrument & Supply Room

Access to Emergency Supplies

- Rearranged supplies and labeled bins
- Stocked Emergency supplies in red bins & moved to upper shelves
- Re-labeled frequent use bins with known names
- Grouped related items
Monitor parts easily accessible and visible

Drawer Organization

Monitor Carts
Triage Supply Carts & Caddies
Supplies to Improve Triage Workflow

• Wound care caddies & Specimen cup

• Mayo Stand Carts - Supplies needed for SVE exams

• Decreases Patient waiting time in triage for the Exam Room

• Portable Supplies Carts - Accommodate our inpatient Antepartum population
Triage Stocking & Checking List
Tools to Improve Triage Workflow

- Multidiscipline check list
- Organize checking emergency equipment & supplies
- Detailed Daily Checklist: Staff’s consistency in checking & stocking
Anticipate and Plan for Crisis

- Situational Awareness
- Don’t sleep on the job – Risk assess
- Know the department standards and guidelines
- Have a back up plan for your back up plan
Assume the Leadership Role

- The Primary Nurse

- What happens when the MD enters the scenario?
Communicate Effectively

- Again this sounds so simple
- How exactly does one learn to communicate effectively?
- Are there tools/strategies to promote effective communication?
- Communication is revealed on the video
  - Masks
  - Alarms
  - Incoming staff
Distribute Work Load Optimally

- Avoid the “one woman band”
  - IV start
  - EMR intake
  - Notify staff

- Utilize staff in the area of expertise
  - Respiratory Therapists – blood gas analysis
  - Nursing Supervisor - recorder
Allocate Attention Wisely

- **Finding Twin B**
  - Time sensitive
  - Avoid *fixation* errors

- Avoid flitting
- Finish assigned tasks
Utilize all Available Information

- Lost in Translation
  - Prenatal record
  - Patient hand-offs
  - Nurse to Nurse report
  - Patient transfer

- Utilization Strategies
  - Sharing a mental model
  - Thinking out loud
Maintain professional behavior

- Laughing
- Offensive language
Call for Help Early

- What is the culture - is it safe?
- Every hospital system is unique
  - How exactly does the staff call for help?
  - Variations on shifts and weekends
- What language is used to convey urgency
  - Ensure the staff knows what/how when to call
- Huddles
Identify specific triggers for responding to change in VS and maternal condition...

- Use drills to train staff
- Educate Emergency Dept staff about pregnancy

www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_44.htm
Promote High Reliability

- By conducting a drill you can **actually test** your department’s capability to handle a rare obstetrical triage emergency

- **Measure in minutes**
  - Immediate bedside evaluation
  - Rapid response team
  - Stat lab turn around time
  - Expert consultation
  - PRBC’s transfusing after request
  - Time of birth after prolapse cord
  - Magnesium Sulfate bolus infusing
Ability to Debrief

- Rarely is there a record of events & actions
- Rarely is there any systematic debriefing afterwards
- So...how does the team learn for next time?
## Case Presentation

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Documentation: assessment, vital signs, medication. etc</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/5/18</td>
<td>40 yo G6P5 BIBA MB Peds ED  c/o vomiting blood stated and appeared pregnant  Medical Hx: Atrial Fibrilation, Congenital heart disease, Pulmonary Embolism Delusional psychiatric disorder</td>
<td></td>
</tr>
</tbody>
</table>
3.1 Care throughout labour and birth

- Care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth – is recommended

  • Training of interpersonal communication skills
  • Monitoring disrespect and abuse
  • Staff mentorship
  • Improving staff conditions
  • Develop a policy to promote RMC
Consensus Bundle on Maternal Mental Health

Eliminate Disrespect

- A Road Map for Advancing the Practice of Respect in Health Care: The Results of an Interdisciplinary Modified Delphi Consensus Study.

- Leaders must champion a culture of respect and dignity
- Share responsibility (Multidisciplinary) that promotes accountability
- Engage and support health care work force
- Partner with Patients and Families
- Establish a system to learn and improve the practice of respect
Developing a framework for recognizing and describing disrespect is the focus of this research.

Further process events through a system of risk-based prioritization* to focus attention and resources on the subset of events that represent the highest risk.


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Office of Origin: Environment of Care

I. PURPOSE AND SCOPE

To provide guidelines for the multifaceted Workplace Violence Prevention (WVP) Program that covers all patient care clinics, units, services, and operations under the licenses of UCSF Medical Center, UCSF Benioff Children’s Hospital San Francisco, and UCSF Langley Porter Psychiatric Hospital and Clinics. As part of Injury and Illness Prevention Plan (IIPP), the WVP Program is specific to the hazards and corrective measures for the unit, service, and/or operational locations within the scope of the policy and will be available to employees at all times.

WVP Program covered by this policy includes any act of violence or threat of violence that occurs at the worksite.
Actions to Minimize Violence

In the event that you are concerned about the escalating behavior of another person, here are some suggestions to address the behavior.

<table>
<thead>
<tr>
<th>DO</th>
<th>DO NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project calmness, move and speak slowly, quietly and confidently.</td>
<td>Use communication that generates hostility such as apathy, the brush off, coldness, condescension. Avoid going strictly by the rules or giving the run-around.</td>
</tr>
<tr>
<td>Be an empathetic listener. Encourage the person to talk and listen patiently.</td>
<td>Reject all of the individual’s demands from the start.</td>
</tr>
<tr>
<td>Focus your attention on the other person to let him/her know you are interested in what he/she has to say.</td>
<td>Pose in challenging stances such as standing directly opposite someone, hands on hips or crossing your arms. Avoid any physical contact, finger pointing or long periods of fixed eye contact.</td>
</tr>
</tbody>
</table>
Does the woman or fetus have URGENT/PRIORITY 2 vital signs?

- OR
- Is the woman in severe pain without complaint of contractions?
  - OR
- Is this a high-risk situation?
  - OR
- Will this woman and/or newborn require a higher level of care than institution provides?

**URGENT/PRIORITY 2**

Abnormal Vital Signs
- Maternal HR >120 or <50.
- Temperature >101.8°F, 38.3°C, RR >26 or <12, SpO2 <95%; SBP >140 or DBP >90 symptomatic or <80/40, repeated: FHR >160 bpm for >60 seconds; decelerations

Severe Pain: (unrelated to ctx) x7 on a 0-10 pain scale

Examples of High-Risk Situations
- Unstable, high risk medical conditions
- Difficulty breathing
- Altered mental status
- Suicidal or homicidal
- <34 wks c/o of, or detectable, uterine ctx

≥34 wks with regular contractions or SROM/leaking with any of the following
- HIV+
- Planned, medically-induced cesarean (maternal or fetal indications)
- Breech or other malpresentation
- Multiple gestation
- Placenta previa

Transfer of Care Needed
- Clinical needs of woman and/or newborn indicate transfer of care, per hospital policy

Elizabeth A. Howell, Haywood Brown, Jessica Brumley, Allison S. Bryant, Aaron B. Caughey, Andria M. Cornell, Jacqueline H. Grant, Kimberly D. Gregory, Susan M. Gullo, Katy B. Kozhimannil, Jill M. Mhyre, Paloma Toledo, Robyn D’Oria, Martha Ngoh, and William A. Grobman

The 5h R – Reduction of Disparity
• Including Intrahospital differences i.e. within an individual hospital
Moral Distress Responses

- Emotional
- Physical
- Behavioral
- Spiritual

Although nurses’ primary obligation is to their patients, they also have an obligation to address their own suffering.
What Nurses Can Do to Address Moral Distress

- The American Association of Critical-Care Nurses’ 2006 public policy statement on moral distress

Addressing Moral Distress requires Making Change!

4 A’s

1. Ask
2. Assess
3. Act
4. Affirm
Triage Fishbone
Psychosocial considerations
Community Resources
Improving Care of Patients in Triage

**Policies**
- Rule that patients in Triage must be monitored or discharged
- Thought that PHI cannot be shared between UC and SFGH
- EMTALA – immediate medical screening exams

**People**
- No Psych in house
- No Social Work in house/on call overnight
- Lack of training on trauma informed care
- Limited training on how unconscious bias affects our patient interactions
- Patient refusal of care/discharge plan
- Long wait times in Triage make patients more agitated

**Environment**
- No safe room
- Usual workload does not permit providers/nurses to spend adequate time with patients
- Patient behavior can be disruptive to environment and affect care for other patients

**Process**
- Security often called to help with disposed
- Patients often discharged overnight to street
- Lack of ownership over patients
- Lack of standardized workflow
- Current process leads to animosity between residents and nurses and trauma for all involved

**System**
- No guidelines on criteria for shelters or programs for where we can send patients after discharge

**Patients with complex social situations do not receive equitable, high quality care in Triage.**

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E. Nicole Teal, MD/MPH, Resident, PGY-3
Mapping out the road ahead
Summary

- Telephone triage may be a safe and cost effective means to initiate patient evaluation
- Many women present to the hospital for evaluation prior to their admission for labor and birth
- Nurses play a key role in triage and discharge
- Some nurse conduct MSE in the absence of direct evaluation by a physician per EMTALA
- Mother and baby should be stable prior to discharge
- A thorough evaluation to rule out labor and potential complications as well as confirmation of maternal-fetal well being is critical
- Utilization of AWHONN’s MTFI promotes immediate recognition and multidisciplinary response aimed to prevent severe maternal morbidity and death
Nurses are a valuable source of information and support for women and their families.